

GORWEL – WORKING PAPER NO. 1

The Social Services and Wellbeing (Wales) Bill – A challenge unmet a working paper

by Axel Kaehne and Helen Taylor



GORWEL

Y Sefydliad Cymreig ar gyfer Syniadau Newydd
The Welsh Foundation for Innovation in Public Affairs

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Gorwel Ltd

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Who are Gorwel?

Gorwel has been established for those people who believe that the future of the Welsh economy is in the hands of all people in Wales, and that good ideas can come from people of all political parties and none. We believe that there has to be a better economic future for Wales and that across both public and private sector there are different or better approaches we can adopt to improve the Welsh economy and make the nation truly successful in business.

We have established Gorwel as a non-profit making company limited by guarantee. Gorwel does not receive any government funding and from the outset it has been funded by small donations or from money paid to undertake research activity. In the spring of 2013 it is Gorwel's aim also to become a registered charity.

Gorwel's aim and mission

Gorwel is an independent, non-party Welsh think tank whose mission is to set out a better way to deliver public services and economic prosperity in Wales.

Where possible we want to develop Welsh solutions to Welsh problems drawing on the best research and expertise from both Wales and elsewhere.

Our aim is to produce research of outstanding quality on the core issues of the economy, environment, health, education, public sector management and law and order, and on the right balance between government and individual, and to communicate it to politicians and opinion formers in all parties and none in order to create a consensus for reform.

We are determinedly independent and strictly non-party in our approach. We believe that there has been policy failure in relation to public services over a period of years under all governments, and we want to persuade all parties that there is a better way. Our non-party approach is reflected in our cross-party management committee. You can find more information about Gorwel and how you can support us on our website: www.gorwel.co

Author Information

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Summary

Social care is a matter devolved to the Welsh Assembly. The Welsh Government has recently brought forward a Bill for Social Services ¹ that makes significant changes to the way in which social care is delivered in Wales. Prior to tabling the legislation, the Welsh Assembly ran a consultation on a White Paper which received almost 300 responses from organisations and the wider public. The Bill is being debated by Assembly Members at present and will continue with stage 1 scrutiny in plenary sessions.

This working paper is a response to the Bill as presented by the Welsh Government. The authors aim to make a contribution to the debate about how to fund social care in Wales in the future. The paper will set out the challenges for social care in Wales, give a brief overview of how the Welsh Government intends to respond to these challenges, and finally sets out an alternative set of solutions.

The authors strongly believe that social care and health care represent the most important public policy area amongst devolved matters in Wales. Given the limited resources for the care sector in the Welsh budget, innovative solutions need to be found. Whilst the Bill tentatively moves into the right direction in some areas, fundamental inconsistencies and weaknesses of current care systems in Wales would remain in place.

We make several recommendations which address these remaining weaknesses and speak to the complexity of a care system that is partially administered by devolved government as well as defined by Central Government. We argue that there are two areas which require urgent attention from lawmakers in Cardiff: funding and care infrastructure.

Centrepiece of future funding should be a public option of a mandatory care insurance which covers the basic care needs of everyone. As social care funding is not a devolved matter per se, this recommendation corresponds to plans of the Westminster Government to promote an insurance market for social care in England and Wales. In addition, a public mandatory option for everyone would resonate with the strong feelings of solidarity and reciprocity amongst people in Wales.

On the provider side, we recommend to further diversify the supply landscape in Wales by promoting and encouraging care co-operatives. This would strengthen choice and control for users and there are excellent existing examples of functioning co-operatives in Wales that provide a blueprint.

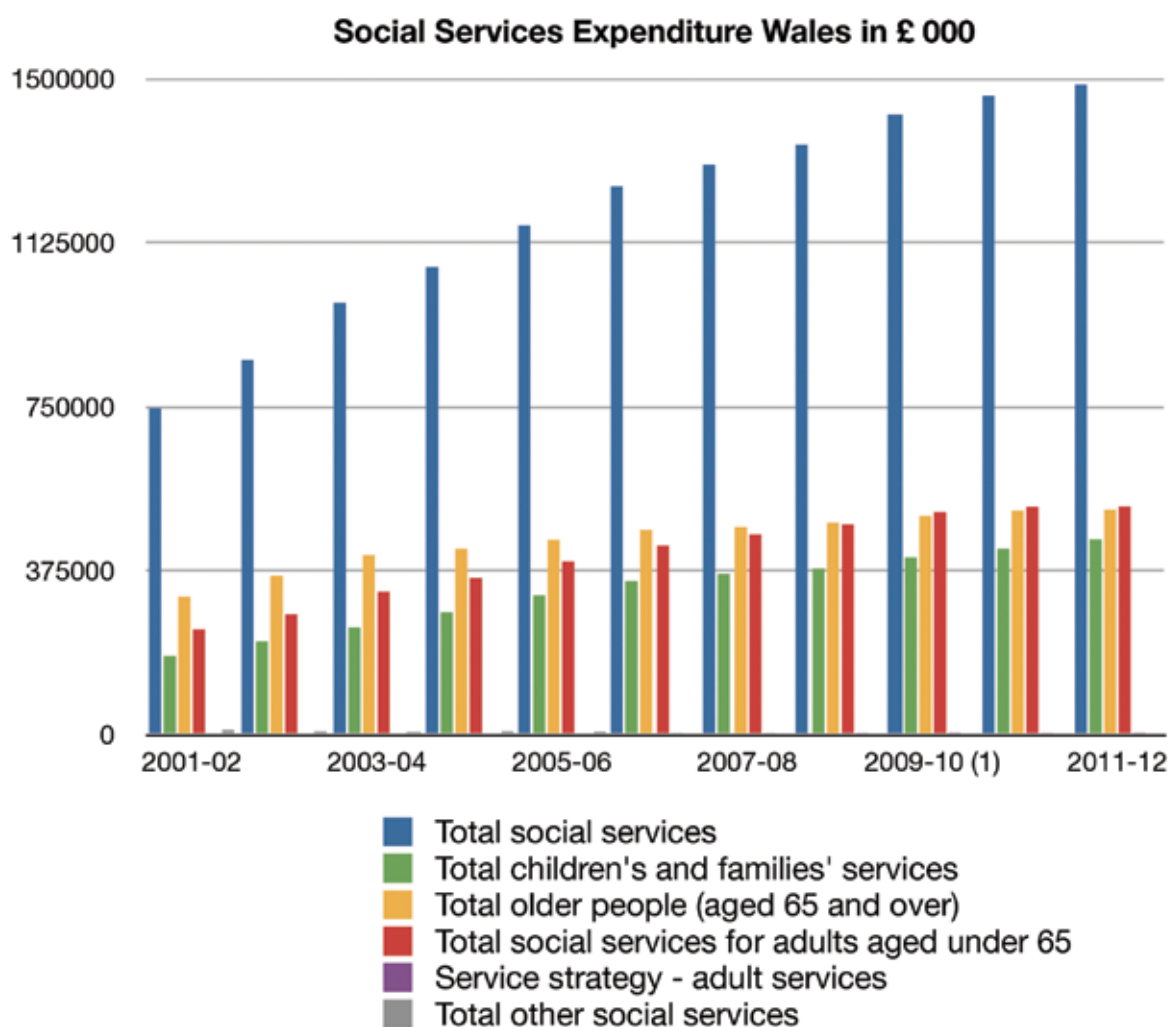
¹ <http://wales.gov.uk/topics/health/socialcare/bill/?lang=en>



The challenge of social care provision in Wales

There are three broad areas which combine to produce an imminent perfect storm for the social care provision in Wales. The first is demographic, the second is financial and the third is organisational. We will briefly sketch each below.

Social care is currently provided by local services to about 65,000 adults in Wales. In addition, around 18,000 families with children are also recipients of social care. The numbers of recipients of social care however do not give an adequate and robust picture of the current need for social care in Wales since the numbers only reflect those who are actually receiving care, and do not include those who do not qualify under the current eligibility regime or never apply for care support.



Social care expenditure gives a better picture of the recent explosion of care in Wales. Between 2001 and 2012, the social care expenditure for children rose from £180 million to £447 million. The expenditure for adults under the age of 65 also more than doubled from £240 million to £521 million in the same period. At this rate of increase, social care expenditure would take up an ever growing and significant part the annual Welsh budget.

There are many reasons for this explosion in care expenditure. Broader definitions of care needs are one, but demographic changes are also a significant contributory factor. Wales certainly has a disproportionately high number of families in need (defined as living below the poverty line) and a higher number of people with disabilities and impairments.² Due to improved health care, people are also living longer which contributes to a considerable rise in care needs. Life expectancy in Wales has risen from 73.3 years (males) and 78.9 years (females) to 77.6 and 81.8 years respectively between 1991/3 and 2008/10 ³. These demographic trends will continue to put additional pressure on care services across all communities in Wales.

Demographic changes also create new care needs. As the population in Wales grows older, age related impairments and illnesses will become more prevalent. Dementia and Alzheimer's are diseases affecting predominantly older people and their support needs can often not be met by families or relatives, but require the care of specialist professionals. Other illnesses are increasingly prevalent amongst the Welsh population such as diabetes (type 1 and 2), due to high levels of obesity and generally poor public health outcomes. They combine to put further strain on community care services in Wales and the upwards trend of prevalence rates amongst the population in Wales shows no abating.

There are additional factors however which add stress to service provision. Over the last decades, many people in need of care were supported by family members. A significant amount of care is in fact delivered by carers in the UK which reduces the amount of care provided by public services. At present, families and relatives provide care to their loved ones in the region of almost £8 billion per annum. As families become more mobile, and employment related migration increases, the amount of care provided by families may fall, to be compensated by local care services. Household composition also changes. Whilst 37 percent of people have lived in families in 1991, only 33 per cent of people are now living in family households and 30 percent in single occupancy households (UK).⁴ This indicates that the contribution of family carers may diminish over time as people become more geographically mobile over their life course and less able to draw on family support.

² <http://wales.gov.uk/topics/statistics/headlines/health2011/111206/?lang=en>

³ <https://stats.wales.gov.uk/Catalogue/Health-and-Social-Care/Life-Expectancy/Life-Expectancy-by-Gender-Year>

⁴ <http://www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-for-local-authorities-in-england-and-wales/stb-2011-census-key-statistics-for-england-and-wales.html#tab---Household-composition>

The demographic challenges go hand in hand with a serious rise in the costs of providing care. This applies to social care as well as health care and most observers accept that the link between the two is significant. As health care costs increase due to the need for more sophisticated technology and medication, the nature of care changes. Whereas previously, patients were being cared for in hospitals which is expensive, now health care is preferably dispensed to patients in their home where possible. Hospitalisation is not only expensive, it is also deemed stressful for the patient and exposes them to risks of hospital acquired infections. Home care is therefore the preferred *modus operandi* for health care professionals. This shifts the costs of care provision to the social care sector which is often ill prepared to cater for patients with complex care needs.

The changes in health care thus have significant implications for social care needs in the long run. Pressures on modern health care systems have also effected a change of emphasis from ameliorative to preventative care. Again, it is the community nursing and social care sector that provides most support to prevent unplanned hospitalisation or acute treatment. As health care provision changes, additional pressures are put on district nurses and social care staff in the communities.

Most observers agree that the key to solving the challenges that social services face through demographic trends and exploding financial burden, lies in improved co-ordination between care providers. Unfortunately, Wales has a fragmented care provider landscape without a comprehensive unifying eligibility and assessment regime. Social services in local authorities have moved from providing services directly to users to brokering services provided by other organisations in the community.

In addition to this, the UK has instituted a sectoral division between health and social care provision in the National Health Reorganisation Act 1973.⁵ Henceforth, social care (children's and adult services) were lead managed by local authorities, whereas health care (including nursing care for health related problems) remained in the NHS which became an autonomous provider. The division between social care and the NHS is seen as the most fundamental obstacle to provide effective care for patients outside hospitals.(Oliver, 2005, Williams, 2007, Hudson and Henwood, 2002, Glasby et al., 2011).

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⁵ <http://www.legislation.gov.uk/uppga/1973/32/contents/enacted>

As health care is a devolved matter for the Welsh Assembly, and England has engaged in a large scale reform of the NHS with the Health and Social Care Act 2012, the Welsh Government is free to develop its own proposals for a new care landscape that suits the needs of people in Wales. The Bill before the Assembly should therefore be judged on whether it rises to this challenge and heralds the dawn of a new care system in Wales.

The current Bill and its critics

Politicians in England and Wales are acutely aware of the challenges to social care and both the Westminster Parliament and the Welsh Assembly are about to introduce changes that are supposed to bring improvements to the way social care is funded and delivered. The Welsh Government has invited consultations to its White Paper on Social Care in 2012 and the Westminster Government is currently finalising its proposals for England. A brief look over the border to England may be helpful, given that health and social care in Wales was previously governed by Westminster (through the Welsh Office) and hence shares with England not only a history of organisational approaches in the care sector but also the same legislative legacy up to 1999.

The main focus of the national debate has been how to fund care. At present, children's services are free of charge to users whilst adult social care is means tested, and thus essentially part funded by users and local authorities. Local authorities set eligibility criteria which are applied through an assessment process. Once people are deemed eligible for care, they self-contribute up to £70,000 where personal assets permit. The review of social care by Andrew Dilnot recommended a change in the funding arrangements and proposed to cap self-contributory payments to £25,000 or £50,000.⁶ The government in Westminster is bringing legislation forward to introduce a life time cap for social care contributions at around £75,000.

The Labour's Westminster Shadow Health Secretary Andy Burnham suggested to go further. He proposed to combine NHS and social care to provide integrated care for people in the community. His proposals however do not spell out in detail whether social care would be relocated within the NHS system or NHS community provision would migrate to local authorities. Given that social work has long fought the medicalisation of care through health professionals, it is difficult to see that Burnham's proposals will be welcomed by frontline staff in local social services. There are some pilots for integrated care in England and Wales but they are judged a failure due to high staff turnover.

⁶ http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/Features/DH_128017

The interests of providers rather than users lie at the centre of both the English and the Welsh care system. Service provision is determined by available funding and there is a tendency to use the eligibility and assessment regime as the main mechanism to regulate access to care.

Burnham's proposals also raise a host of other problems. He would like NHS hospitals to expand their services into communities, perhaps even running community care homes. However, current NHS provision is free at the point of delivery, whilst social care support is means tested. Merging community care under the NHS requires either to drop means testing altogether or to means test NHS services. Either solution would run into serious opposition and raises the question of how to fund care and support delivered in the community.

None of the current proposals however are tackling one of the most fundamental problems in the English or Welsh care system. Both systems are riddled with inconsistencies and disparities in care quality. Crucially,

both systems are governed not by what is needed locally, but by what can be funded. This often leads to rationing of services and poor standards.

At the centre of both the English and the Welsh care system lie the interests of providers rather than users. Service provision is determined by available funding and there is a tendency to use the eligibility and assessment regime as the main mechanism to regulate access to care.

Successive governments have recognised that the current care system is mainly operated around the structures established by care providers rather than the needs of users. The public debate has therefore revolved around how to introduce more flexibility to care provision and more responsiveness of care providers to the needs of users.

Since 1995, the government (prior to devolution of social care to the Welsh Assembly Government) piloted several different mechanisms to address these problems. Social care and health care gradually moved to person centred planning, which supposedly puts the needs of patients and users at the centre of provision. In theory, support interventions are designed after careful assessments of needs.

Successive governments also recognised that users were conspicuously absent in the design of services. Two mechanisms were supposed to bring change. First, user representatives were given a voice with commissioning boards in health and social care, which was supposed to increase the accountability of providers. However, there is little evidence that user representatives can effectively challenge decision making by professionals (Horrocks et al., 2010, Kaehne and Catherall, 2013, Williams et al., 2010).

Another mechanism to bring about positive change was to introduce personal budgets and direct payments. This resonated with the need to put users in control of what they receive. It thus emerged at the intersection of the debate about choice in public services, and personal control over what users and patients needed. The discussions about marketisation of public services, the employment of public management principles to all services funded by the tax payer and the need to subject public services to proper managerial controls fed into this debate.

Parallel to this, health and social care providers were also undergoing considerable change. The New Labour government under Tony Blair strengthened the drive towards partnerships in public services and co-operation between public, private and third sector organisations (Dickinson and Glasby, 2010). Provision of services gradually moved from being exclusively a public services domain to a mixed economy provision.

The emerging picture is one of a clear consensus in England and Wales about the need to reform social services, to ensure sufficient funding is available and the need to mitigate the effects of the division between health and social care. Following devolution of health and social care to the Welsh Assembly, the people in Wales have a unique chance to develop their own solutions to the problems that are produced by an aging population with ever higher care needs and increasing demands for high quality social care in the community.

The key question for politicians is how to bring about the necessary changes. In essence, it is a question about identifying the most effective drivers for positive change.

The key question for politicians in Cardiff Bay and in Westminster is however how to bring about the necessary changes. It is a question about the capacity to introduce change, steer the care sector in the right direction without disrupting care provisions to the population in need. In essence, it is a question about identifying the most effective drivers for positive change. The direction of travel is framed by the need for personalised services, limited resources, and rising care needs in the population. The current Social Services Bill by the Welsh Government tries to triangulate this constellation of problems and challenges without adequately responding to any of those.

The Bill's journey through the Assembly

The Social Services and Well-being (Wales) Bill has proved contentious throughout Stage 1 scrutiny. Introduced in January 2013, the Bill completed the first stage of scrutiny in June 2013.

The Bill introduces four broad areas of change: a focus on wellbeing, an equal approach to adult and child services on a statutory footing, a ministerial prerogative and a commitment to the integration of services. The Deputy Minister for Social Services (Gwenda Thomas) has emphasised that the Bill takes a 'people approach' to social services. Throughout the Bill a commitment is given to person centred care with individuals being fully involved in the organisation of their care and an emphasis placed on prevention. This includes a focus on control and independence for those using services and in turn the Bill promotes the use of Direct Payments. The initial Explanatory Memorandum for the Bill states that it will "transform the way social services are delivered, primarily through promoting people's independence to give them stronger voice and control."

Linked to this is the second major area of change: the equal statutory footing of children and adults in the Bill in regards to social services. The new approach provides for a duty for local authorities to undertake an assessment of all individuals, children and adults, if they present care needs. Consequently, the Bill proposes to establish national safeguarding boards which could entail merging children and adult safeguarding services. The Explanatory Memorandum states that the Bill aims to provide a "common set of processes, *for people*."

The third area of change is the introduction of a ministerial prerogative for the provision of services. This the Deputy Minister describes as the power "to intervene in the exercise of social services functions by a local authority following the issue of a warning notice." This again feeds into the 'people approach' of developing national standard and outcome frameworks for care and social services across Wales. These would apply to both children and adults, with the Minister having ultimate responsibility to ensure that these frameworks are complied with nationally.

The final area of change is the emphasis on integrated services. This has been an area of frequent debate during scrutiny sessions. Although the Bill does not place a duty on health and social services to collaborate, the Deputy Minister has emphasised that it provides for the integration of services. She intends the Bill therefore to promote a holistic approach to services, place a duty on local authorities to provide preventative services and encourage health and social

services to cooperate. In her introduction of the Bill the Deputy Minister stated that “it provides the statutory framework to deliver the Welsh Government’s commitment to integrate social services to support people of all ages, and support people as part of families and communities.”

Much of the initial debate in the chamber has centred on the Government’s claim that the Bill is cost neutral. Subsequent scrutiny sessions included a raft of criticisms from both stakeholders and Assembly Members (AM) covering all aspects of the Bill. Most stakeholders and AMs welcomed the intention of the Bill in terms of a person centred approach with an emphasis on prevention but almost all criticised the lack of detail in the Bill and the imbalance between principles on the face of the Bill and those left to be developed through regulation. The biggest area of contention has been that the Bill does not include eligibility criteria; therefore there is no indication of who the Bill will affect. This has led to fierce criticism from some AMs and multiple stakeholder groups who claim that they cannot fully scrutinise the Bill due to lack of detail.

The emphasis on prevention and integrated services in regards to finance has also proved to be a point of contention. The WLGA, alongside Assembly Members, has questioned whether the Bill really can be cost neutral. The organisation also criticised the emphasis on preventative services as being an added expectation on social services. The Bill provides for charging for services, including advice and preventative services and extends this to 16 and 17 year olds as a potential way of addressing financing issues and this has also been criticised.

At present, it appears that the Bill has run into strong criticism from both AMs and stakeholder groups. However, as an aspirational statement the Bill enjoys widespread support and the aims of providing person centred care and a national approach to standards and outcomes have been welcomed. The Bill is criticised for failing to address some issues whilst, most pertinently, providing insufficient detail on how to achieve its ambitious aims.

The problem of legislating for better care

Overall, it appears that critics of the Bill have formulated some thoughtful critical arguments during the consultation period. They have pointed to two significant weaknesses in the Bill. First, the Bill attempts to reduce disparities and inequalities of care provision across Wales by arrogating more powers to the Minister. Local authorities have so far been able to define eligibility criteria in such a way that available resources matched assessed need. This led to rationing of services but also to large differences in care provision across local authorities.

Strengthening the powers of the Minister to intervene in provision may bring about a standardisation of eligibility across all local authorities (and hence reduce the post-code lottery) but local authorities thereby also lose the ability to match resources to needs. This has serious implications for funding and accountability. Increasing ministerial powers to define needs requires careful balancing of resources on a national level. Critics argue that it is not clear that the desire to introduce a national eligibility framework is matched by a willingness or ability by the Welsh Government to provide additional resources.

The second broad aim of the Bill is to effect a shift of social service provision to include prevention. Whilst this has been widely welcomed, critics point out that such a shift requires additional resources and a redefinition of eligibility criteria. It is not clear that the Bill provides sufficient guidance on how eligibility is affected by the aim to include prevention in care provision.

The Bill also takes a mainly aspirational stance on questions of partnership and care integration. The Bill appears to be poorly co-ordinated with the Health Department whose own bill on the Welsh NHS is forthcoming. In effect, the professional silos that dominate frontline practice in health and social care are mirrored by the governmental divisions between departments. The Social Services Bill hence articulates only aspirations about pooled budgets, and integrated care pathways but fails to formulate the vehicles that can facilitate collaboration across the care sectors. In effect, the Bill states the need for a universal care system but does not specify how this may be achieved.

Most crucially, the Bill lacks the mechanisms that can drive positive change. There are two main reasons for this. First, there is an ideological commitment of the Welsh Government to prevent the introduction of any market orientated mechanisms to replace political steering in social services. The Welsh Government believes that a strengthened vertical structure will allow ministers to direct local

authorities to introduce positive change. It is in effect advocating increased top down management, potentially leading to micro managed local services by the Welsh Minister. It fundamentally mistrusts any other steering mechanisms in the public domain other than governmental directive.

The second reason is that the Welsh Government adheres to a simplistic understanding of organisational behaviour. In essence, what sustains the main principles of the bill is a largely misguided belief that problems can be solved through imploring professionals to do the right thing. This approach has a long history with Labour governments (Darzi and Howitt, 2012, Glendinnig et al., 2005, Wistow and Dickinson, 2012). The Bill is suffused with normative language and terminology, which is a reflection of the conviction that outcomes would improve if everybody just does the right thing (Dickinson and Glasby, 2010, Margetts et al., 2010, Glasby et al., 2011). This goes hand in hand with a conspicuous absence of outcomes that can be measured, and benchmarks that allow the people in Wales to hold its government to account (Howarth and Haigh, 2007, Goodwin et al., 2011, Lowe, 2013).

At the core of the bill is thus an absence of robust accountability structures, a conspicuous lack of innovative thought and a baffling naivety about how to steer large public services towards positive change.

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What's the answer?

The key to any effective reform of social services is to acknowledge two concerns: the complexity of care needs and the limited ability to steer complex organisations centrally. Awareness of these two limiting factors leads observers to a better appreciation of the challenges of social service reform in a mixed economy. In addition, there are certain benchmarks that frame past and present reforms which should be considered as irreversible parameters of the care landscape.

First, care will have to be provided as person centred as possible. The needs of patients and service users will define not only which services are needed but also how services are provided (at home, during flexible working hours). Second, there will also be increasing needs of community care due to demographic changes and the rising costs of hospital care. Limited resources require improved efficiency and better co-ordination between services.

The better alternative is to allow those who have the greatest interest in the reform of care services to drive the changes. Thus, care should be defined and shaped by the user, rather than the provider.

The Welsh Government's Bill has responded to these challenges with two main developments: to reframe the definition of needs to include well-being, and to increase the capacity to steer services centrally. Both developments disregard fundamental realities of care organisations operating in complex public service contexts, serving a population with a highly diversified needs profile, resulting in a mismatch between central steering capacity (micro-managing) and flexible delivery.

The alternative is to reframe the question of who can drive change effectively for everyone. At present the Bill's main strategy amounts to little more than exhorting everyone working in care services to do better. This is a familiar trope of top down organisational reform in the UK (Margetts et al., 2010). There is wide recognition now that although public service reforms should be in the interest of users they are often reflecting the interest of those who work in public services. The discourse on serving the public interest or producing a 'public good'

is misleading in the context of public service reforms, as service users or patients do not have the capacity to effectively articulate collectively what this 'public good' ought to be.

The alternative is to allow those who have the greatest interest in the reform of care services to drive the changes. To do this, they would have to be in a position to determine the care they receive. Whereas at present, care services are being delivered to the user, ideally care should be defined and shaped by the user. This implies a radical shift from a supply orientated system to a demand driven service.

How to create a demand driven care system

Two conditions of the current care system hinder the development of a truly demand orientated system: limited resources and an assessment regime that is controlled by providers who define care needs as well as care provision.

The New Labour government already recognised the role direct payments and personal budgets played in order to break the link between controlling access and defining care needs, essentially by weakening the connection between provision of care services and the needs assessment process. However, direct

Empowering users of care means to put them in charge of shaping the care for their individual needs. To do this, they need to have clear entitlements which originate in individual contributions to the care system.

payments have had a problematic history in Wales (Manthorpe et al., 2011, Stainton and Boyce, 2004) as the Welsh Government has discouraged local authorities from promoting them to users for ideological reasons. Personal budgets represent a halfway house between direct payments and the current system in that they permit users to clearly know what services they are entitled to receive. Personal budgets and direct payments provide greater amount of transparency and are thus critical steps in developing more effective and more responsive care systems.

Neither of these mechanisms however introduce sufficient flexibility to take

account of the diversity of needs. The provider of means retains the right to assess the needs which inevitably leads to a conflict of interests. And it seems that empowering the users of care would require a far more radical step than simply increasing transparency of the current care provider processes. Introducing a substratum of decision making or oversight in the form of the Minister is unlikely to reduce care disparities whilst increasing steering complexity in the system. The answer appears to lie in the effective shaping of the care delivery infrastructure to make it more responsive to the needs of users.

Empowering users of care may be achieved by providing more information, but a far more effective step is to put them in charge of shaping the care for their individual needs. However, they can only do this only if they have clear entitlements which

originate in contributions to the care system. We recommend to fund social care through a care insurance system by stimulating a free care insurance market in the UK. Social services would be able to offer their services to individuals in exchange for payments from the insurance providers.

In addition, we also recommend to encourage the formation of co-operative providers in the care delivery landscape with varying degrees of user control. There is some evidence that user controlled care co-operatives improve access and choice of care users (Roulstone and Hwang, 2013).

Individuals could also determine the extent of social care provision for themselves by taking out premiums at different levels. Such a system would preserve an element of solidarity which is likely to resonate with current Welsh sensibilities about collective contributions to individual care needs as insurance systems spread risks across all premium holders. It would also permit users to control the extent to which they would like to contribute to their own care.

Care Insurance with a public option

Establishing a care insurance market would create a truly demand driven system that could insert much needed dynamism for change in the care provision landscape in Wales and the UK in general. The Coalition Government has already indicated that it intends to stimulate such a care insurance market and it is now incumbent on the Welsh Government to respond to this development in such a way that the newly developed care insurance system answers to the needs of care users in Wales.

Two principles should guide the Welsh Government in this regard. First, it should ensure that care insurance options are providing additional flexibility for basic as well as additional care needs. Second, it should make sure that care insurances work together with care providers to create a flexible delivery system with sufficient responsiveness to the needs of users.

One critical step in rendering the new care insurance landscape suitable to the needs of the people in Wales may be to promote and support care co-operatives that can deliver basic as well as additional care support. Such co-operatives could be at the forefront of innovation in care support delivery systems and may make a substantial contribution to increasing user control and choice in care provision (Roulstone and Hwang, 2013).

The second step the Welsh Government should undertake in this regard is to ensure, in collaboration with the Westminster Government, that basic care needs are matched through a public option for low income users. This would remove the link between needs assessments and support provision and place the user in control of configuring their own care provision even for basic needs.

Channeling the funding for all care needs through an insurance system would also prevent the development of a two tier provision in terms of quality with some people accessing care support through an insurance funded market system and others falling back on basic care support provided through local authority care provision.

Recommendations

Take positive steps to influence the developing care insurance market in the UK

Investigate the possibility of providing a public insurance option for basic care needs

Encourage the formation of care co-operatives with varying degrees of user control

Establish a tariff for basic and additional care needs in collaboration with care insurance providers

References

- Darzi A. & Howitt P. (2012) *Integrated care cannot be designed in Whitehall*. International Journal of Integrated Care, 12, 1-3.
- Dickinson H. & Glasby J. (2010) *'Why partnership work doesn't work': pitfalls, problems, and possibilities in English health and social care*. Public Management Review, 12, 811-828.
- Glasby J., Dickinson H. & Miller R. (2011) *Partnership working in England - where we are now and where we've come from*. International Journal of Integrated Care, 11, 1-8.
- Glendinnig C., Dowling B. & Powell M. (2005) *Partnerships between health and social care under 'New Labour': smoke without fire? A review of policy and evidence*. Evidence and Policy, 1, 365-381.
- Goodwin N., Smith J., Davies A., Perry C., Rosen R., Dixon A. & Ham C. (2011) *Integrated care for patients and populations: Improving outcomes by working together. Report to the Department of Health and NHS Future Forum from the King's Fund and Nuffield Trust*. p. 20. The King's Fund, London.
- Horrocks J., Lyons C. & Hopley P. (2010) *Does strategic involvement of mental health service users and carers in the planning, design and commissioning of mental health services lead to better outcomes?* International Journal of Consumer Studies, 34, 562-569.
- Howarth M. L. & Haigh C. (2007) *The myth of patient centrality in integrated care: the case of back pain services*. International Journal of Integrated Care, 7, 1-7.
- Hudson B. & Henwood M. (2002) *The NHS and social care: the final countdown?* Policy and Politics, 30, 153-166.
- Kaehne A. & Catherall C. (2013) *User involvement in service integration and carers's views of co-locating children's services*. Journal of Health Organisation and Management, 27.
- Lowe T. (2013) *New development: the paradox of outcomes - the more we measure, the less we understand*. Public Money and Management, 33, 213-216.
- Manthorpe J., Moriarty J. & Cornes M. (2011) *Keeping it in the family? People with learning disabilities and families employing their own care and support workers: Findings from a scoping review of the literature*. Journal of Intellectual Disabilities, 15, 195-207.
- Margetts H., 6 P. & Hood C. (2010) *Paradoxes of Modernization. Unintended Consequences of Public Policy Reform*. OUP, Oxford.
- Oliver A. (2005) *The English National Health Service: 1979-2005*. Health Economics, 14, S75-S99.
- Roulstone A. & Hwang S. K. (2013) *Co-operation and Co-operatives in the Development of Direct Payment Schemes in Wales*. p. 42. Northumbria University, Cardiff.
- Stainton T. & Boyce S. (2004) *'I have got my life back': users' experience of direct payments*. Disability and Society, 19, 443-454.
- Williams I., Dickinson H. & Robinson S. (2010) *Joined-up Rationing? An Analysis of Priority Setting in Health and Social Care Commissioning*. Journal of Integrated Care, 19, 3-11.
- Williams P. (2007) *Learning to Collaborate: Lessons in Effective Partnership working in Health and Social Care*. In: *Design for Partnership*. (Ed. ^)(Eds. p. 38. National Leadership and Innovation Agency for Healthcare, Cardiff.
- Wistow G. & Dickinson H. (2012) *Integration: work still in progress*. Journal of Health Organisation and Management, 26, 676-684.



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